Guidance and advice to clinicians on the relevance of laboratory findings or on the usefulness of laboratory tests in a specific case may, however, need formal medical training.

Concurrently with this growth in complexity of the practice of the sciences there has been an increasing need for efficient, economic, and knowledgable management of the human and material resources of laboratories. Such management has itself become more difficult owing to changes in attitude in society, and to legislation such as the Employment Protection Act and the Health and Safety at Work Act. The MLSOs were quick to appreciate the need for management training and a large majority of those of senior level have now received such training. However, almost all pathologists and the majority of biochemists have mistakenly assumed that management training was unnecessary for them.

It is, therefore, clear that the only staff in present-day hospital laboratories equipped by both training and experience to "manage" the laboratories are the MLSOs. The idea that such management tasks should be "relegated" to "less senior scientific officers" is frankly ludicrous. Management, whether intradepartmental or interdepartmental, needs authority, which comes only with acknowledged seniority. Such authority could be delegated from a director of a department but in the name of "clinical freedom" (whatever that may mean in the laboratory) the laboratory-based medical consultants are resisting having one of their own number being put in charge of the others. This leaves the laboratory without a head and the only interdepartmental authority is that of the senior chief or principal MLSO over the MLSO staff.

If it is accepted that a medical head of a pathology laboratory is necessary then that head should surely, by definition, have authority over all staff, both medical and scientific, and should then carry full responsibility for the policies of the laboratory as a whole. The general management of the laboratory services could then be carried out by the most senior officer trained, both scientifically and managerially, to do the job—that is, the senior chief or principal MLSO.

The tasks of this officer need to be specified clearly in writing. The DHSS did commission a Mr Derek Warlow to assess what these tasks should be and he produced some very clear answers, which the department, for reasons of its own, has not published. The question of whether such a manager should be paid more or less than those in immediate charge of the day to day work of a department is a separate subject and to bring it into this discussion only confuses an already complex issue.

A E BROWN

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District General Hospital,
Hartlepool, Cleveland

SIR,—Ever since the decision of the PT "B" Whitley Council to change the job title of medical laboratory technicians to that of medical laboratory scientific officers there has been frequent confusion between them and the scientific officers whose grading and remuneration is determined by the PT "A" Whitley Council. The latter scientific officers are graduates in science subjects who are employed in haematology, histopathology, and bacteriology departments in a range of grades from basic grade scientific officer to top grade scientific officer. The common title of scientific officer conceals important differences in the quality and scope of the work of these two groups of staff and makes it particularly important to use the full job title in referring to either post.

In the last section of my article "Who Manages Pathology Laboratories?" (9 December, p 1658) I used the term scientific officers when referring exclusively to medical laboratory scientific officers. I trust that this did not cause confusion in relation to the argument about the abolition of the "floating" post.

ROGER DYSON

Department of Adult Education,
University of Keele

**This correspondence is now closed.—ED, *BMJ*.

Nursing at a crossroads

SIR,—I find Mr I G Schraibman's letter "Nursing at a crossroads" (13 January, p 121) inappropriate in many respects. I know the problem very well as my own wife is a qualified nurse. I have taken up a post as registrar in geriatric medicine recently at this hospital, where my wife also applied for a job but was told that there were no vacancies and owing to the shortage of finance they did not know when there would be one.

In my view the problem lies with the educational requirements required for the training of nurses. As most of the training schools require as many as 5-6 O levels, who will be willing to take up nursing as a career, working long unsociable hours day and night with poor pay and no promise of a post at the end of the training? I clearly remember final year student and pupil nurses being forewarned that they all could not be guaranteed jobs at the end of their training.

At the end of his letter Mr I G Schraibman suggests reduction of shifts, with less overlap so that no increased numbers of staff would be needed. But this surely would not work.

But I fully agree with Mr Schraibman that nursing is at a crossroads and that there must be a radical rethinking of its role—not because people do not want to become nurses but because of the high educational standards required and no guarantee of a post at the end of their training.

H A TALPUR

Department of Geriatric Medicine,
City General Hospital,
Stoke-on-Trent

Normansfield and the NHS

SIR,—The suggestion by Professor Rudolf Klein (23-30 December, p 802) that consultants should be moved at least every ten years to avoid "Normansfield-type breakdowns" deserves closer attention.

Mr G T Watts (13 January, p 131) says that this makes consultants like expendable pawns and points to the social strains of uprooting from a local community, but the problems in Mr Watts's specialty may be different from those in some other fields. In comparing all the consultants in mental handicap in a provincial region with an equal number of consultants in surgery in a non-teaching area of the same region there have been 10 moves within the consultant grade in the former and only one such move among the surgeons. It seems therefore that some of the more enlightened consultants have anticipated Professor Klein's advice; but the new contract, with its wider possibilities for private practice in some fields, may retard its more general application.

T L PILKINGTON

Stockton-on-Tees, Cleveland

Green flashing lights for doctors

SIR,—One does not expect busy doctors to comb the columns of the so-called "popular" newspapers, but as far back as last September the *Daily Mirror* was giving full details of the flashing green light scheme for doctors.

Dr John D W Whitney (20 January, p 201) can rest assured that many drivers, as a result of the publicity given to this scheme in advance, and not only by the *Daily Mirror*, of course, will get the message when the green light flashes.

RONALD BEDFORD
Science Editor

Daily Mirror,
London EC1

Counter-pickets for the NHS?

SIR,—However much one may disapprove of strikes in the Health Service there is little that one can do actively to stop them. When, however, pickets appear at the hospital gates with the avowed intention of persuading or intimidating others—not directly involved in the strike—from delivering essential supplies or entering to do their own jobs, it is time that we acted to protect patients. Counter-pickets—matching in numbers the strikers' pickets—should be there to encourage non-strikers to do their duty to the patients. The driver delivering oxygen supplies may be hesistant to pass pickets who demand union loyalty, but if he is informed that if he turns back lives will be endangered, and reminded that tomorrow it could be his own wife in the theatre, he is more likely to show his loyalty to his fellow human beings and cross the line.

Clearly, working doctors and nurses would not have time to picket duties—but retired doctors and nurses could form a panel of volunteers. If the BMA would organise it a system of "flying pickets" could deal with any situation that arises. I'm sure that many BMA members in the vicinity of a hospital or strike would offer hospitality to a retired colleague who came to act as a counter-picket from a long distance.

As an old-fashioned socialist who puts care of the community before individual gain I would be quite happy to participate in such a scheme. I can see no objection that could be raised by doctors of any political persuasion to ensuring that both sides of the question are presented at the hospital gates. Perhaps doctors and nurses who feel as I do would press the BMA to take action.

LESLIE J TEMPLE

Cemmaes,
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Addendum

Anaesthetists' manpower and staffing

Dr A R ROGERS (St Leonards, Exeter) wishes to make it clear that his letter (13 January, p 130) in no way refers to any local consultants.